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**TO** MidCentral District Health Board

MIDCENTRAL HEALTH

**FROM** Lyn Horgan  
Operations Director  
Hospital Services

**DATE** 3 November 2010

**MEMORANDUM**

**SUBJECT MCH Specialist Diabetes Service – Service Reconfiguration, Potential Impact, Mitigations & Measures**

**1. PURPOSE**

In line with the recent Diabetes Service review at MidCentral Health (MCH), this paper sets out proposals for a reconfiguration of the service in order to meet the proposed reduction of 1.0 FTE Clinical Nurse Specialist (CNS) and 0.5 FTE Administration.

**2. SUMMARY**

Inclusive of the Nurse Practitioner (NP), the diabetes service nursing staff has a budget of 5.90 FTE for the 2010/2011 year.

A proportion of this nursing FTE was funded via a Service Level Agreement (SLA) that expired in June 2009. Currently the 4.90 CNS FTE includes a 1.00 FTE temporary position. This position was to provide for 'nursing backfill' to allow MCH specialist diabetes nurses to provide education and training to the 6 FTE generalist diabetes nurses providing services in the primary setting. The specific purpose of this SLA has now been fulfilled and MCH no longer receives funding for this position.

Discussions have been held with the Project Sponsor, Clinical Sponsors, Nurse Practitioner (NP) and Medical Head (MH) of the Diabetes Service. The NP and MH then worked closely with Dr Owais Chaudhri, Diabetologist, and the multidisciplinary specialist diabetes team to develop the following proposal. The administrative role has been discussed and advice sought from the Service Manager responsible for clerical staff and the Administration Co-ordinator.

Maintenance of patient safety is of critical importance and, therefore, anticipation of any potential clinical impact of these proposed service changes is vital. It is proposed to reconfigure the service with the aim of minimising the impact on patient safety and outcomes. This may be achieved by distributing reductions in service across both inpatient and outpatient workloads. However, it is recognised that there is a need to plan appropriately for the level of funding available.

Any changes will be subject to ongoing audit, and appropriate parameters by which any potential impact on patient care may be assessed. A phased reduction in services to the

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proposed level will commence in advance of the proposed implementation date, so that full implementation can be achieved without delay. This will allow for a clear audit of the full impact of the reduced level of service. It is proposed that a suitable audit period should be six months.

### **3. RECOMMENDATION**

It is recommended:

that nursing levels be reduced by 1.0 FTE;

that administration levels be reduced by 0.50 FTE;

that the reconfiguration of the Diabetes Service provide financial benefits of no less than \$100,000;

that a post event audit review of the Diabetes Service reconfiguration be conducted by November 2011.

## 4. PROPOSED RECONFIGURATION

### 4.1. Clinical Nurse Specialist 1 FTE Reduction

Impact upon patient safety and outcomes in any one area of service will be minimised by distributing the reduction of 1.0 FTE as 0.5 FTE from inpatient cover and 0.5 FTE from outpatient services. It is anticipated, however, that there may be the potential for impact on bed occupancy rate, inpatient length of stay (LOS) and patient outcome measures.

### 4.2. Inpatient Services (including Emergency Department and MAPU)

- CNS cover for inpatients to be reduced to 1.5 hours per day only (saving 0.5 FTE).
- Priority will be given to high-risk/vulnerable groups (e.g. pregnant women, children and young adults).
- Other patients will be seen as workload allows. Patient care will not be compromised as the hospital is a place of safety with clinical input from a range of professional groups e.g. medical, ward nursing and therapy staff.
- The NP will continue to provide specialised care across secondary settings as is currently provided. The NP role will continue to provide senior clinical leadership within the diabetes specialist team, mentorship of the clinical nurse specialists, and quality assurance activities within MidCentral Health.
- The admitting General Medical Physicians will take more responsibility for the diabetes component of patient care. Education and upskilling will be provided by the diabetologists. With the recent appointment of Dr Chaudhri, MCH now has two diabetologists providing specialist diabetes services which now alleviates some of the sole Diabetologists workload.
- MCH medical staff seeking advice regarding patients will continue to refer to the Diabetologists.
- Audit measures to include length of stay, admissions through ED, bed occupancy rates and clinical incident reporting.

### 4.3. Outpatient Services

- The current 0.3 FTE allocated to CNS-led clinics in Levin, Massey, Feilding and Dannevirke will be reviewed and reprioritised within the current FTE allocation.
- A review of outreach clinics with Levin potentially being held monthly and the potential for Dannevirke to have a diabetologist SMO clinic.
- The potential to review the Feilding clinic given patient volumes and transfer patients to MCH CNS clinics.
- CNS-led clinics at Palmerston North to be reduced by 0.2 FTE, with ring fencing of services to vulnerable groups and to more complex patients seen with other specialties (e.g. obstetrics, paediatrics, renal medicine).
- The NP will continue to provide specialist clinics as is currently provided.
- The booking times for CNS-led clinics will be managed by clinical priority as is the same for all booking lists across the organisation.
- The two diabetologists will continue to provide First Specialist Assessments (FSA) and Follow Up (FU) clinics at MCH, Horowhenua and will investigate the potential to provide a clinic at Dannevirke given the increase in diabetologist staffing.
- Telephone follow-up services will continue however the diabetes service will work on reviewing the number of telephone contacts currently undertaken with a view to some reprioritisation. Once this work has been completed any potential time saving will be reallocated into inpatient services.
- Audit measures to include booking times, booking list length, admissions via ED and HbA1c.

#### 4.4. Administration Support 0.5 FTE Reduction

A 0.5 FTE reduction in administrative assistance may impact given the current administrative provision to the service. However, there are a number of organisational processes and systems that support a number of services that have 1.0 FTE clerical support only.

Reception would be unattended at lunch time, but this occurs in other non acute clinical service areas that have one person in the office. An answer phone is already available within the Diabetes Service.

Currently clinic letters are being typed on the day of dictation and the MCH turnaround time is up to three days so this is an area that can be extended within the service. Urgent typing will still be completed on the day.

Diabetes referrals are loaded in the Central Referral Office and distributing these for prioritisation within the service is a priority function within all clerical roles across the organisation. This priority function will not change.

The potential of any increase to Did Not Attend (DNA) rates by not telephoning the patients as is currently done by diabetes clerical staff can be mitigated by this function being provided by Central Patient Enquiries who perform this role for approximately 20 other clinics across the organisation.

All administrative activity will be monitored and changes made if necessary. This will be managed by the Administration Coordinator responsible for the administrative staff within the Diabetes Service.

**5. PROPOSED CHANGES**

<b>INPATIENTS</b>			
<b>Current Service</b>	<b>Proposed Service Change</b>	<b>Potential Impact/Mitigations</b>	<b>Audit Measure</b>
<ul style="list-style-type: none"> <li>• 0.7 FTE allocated for inpatient cover.</li> <li>• CNS available by pager Monday to Friday 0800-1700.</li> <li>• Respond to referrals from:               <ul style="list-style-type: none"> <li>○ ED &amp; MAPU</li> <li>○ Medical wards</li> <li>○ Surgical wards</li> <li>○ Paediatrics and Obstetrics services</li> <li>○ Mental health wards</li> <li>○ Rehabilitation/ElderHealth</li> </ul> </li> <li>• Provide assessment, treatment advice, education and input into discharge planning.</li> <li>• 5-6 referrals typically seen each day.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction of inpatient cover to 0.2 FTE.</li> <li>• CNS available by pager Monday to Friday 1000-1130 only.</li> <li>• Priority will be given to high-risk/vulnerable groups:               <ul style="list-style-type: none"> <li>○ Patients admitted with DKA.</li> <li>○ Pregnant patients.</li> <li>○ Children and young adults.</li> </ul> </li> <li>• Other patients will be seen as workload allows. Patient care will not be compromised as the hospital is a place of safety with clinical input from a range of professional groups e.g. medical, ward nursing and therapy staff.</li> </ul>	<p>There is the potential for the following:</p> <ul style="list-style-type: none"> <li>• Increased admissions through ED.</li> <li>• Increased bed occupancy (medical and surgical).</li> <li>• Increased length of stay.</li> <li>• Increased readmission.</li> <li>• Increased medication errors.</li> <li>• The NP will continue to provide specialised care across secondary settings as is currently provided.</li> <li>• The admitting General Medical Physicians will take more responsibility for this component of patient care. Education and upskilling will be provided by the Diabetologists.</li> <li>• Medical staff seeking advice regarding patients now have two diabetologists to refer to which now alleviates some of the sole diabetologist's workload.</li> </ul>	<ul style="list-style-type: none"> <li>• Admissions through ED.</li> <li>• Bed occupancy rates for medicine and surgery.</li> <li>• Length of stay.</li> <li>• Readmission rates.</li> <li>• Medication errors/incident reporting.</li> </ul>

<b>OUTPATIENTS</b>			
<b>Current Service</b>	<b>Proposed Service Change</b>	<b>Potential Impact/Mitigations</b>	<b>Audit Measure</b>
<ul style="list-style-type: none"> <li>• 1.3 FTE CNS-led clinics for vulnerable groups (e.g. children, pregnant women).</li> <li>• Includes fortnightly repeat paediatric follow-up clinic.</li> </ul>	<ul style="list-style-type: none"> <li>• No change proposed.</li> <li>• Services to vulnerable groups to be ring fenced.</li> </ul>	<ul style="list-style-type: none"> <li>• Impact neutral.</li> </ul>	<ul style="list-style-type: none"> <li>• Mean HbA1c value.</li> <li>• Outcomes of pregnancy.</li> </ul>
<ul style="list-style-type: none"> <li>• 0.3 FTE CNS designated for outreach clinics:               <ul style="list-style-type: none"> <li>◦ Levin (fortnightly).</li> <li>◦ Feilding (monthly).</li> <li>◦ Dannevirke (monthly).</li> <li>◦ Massey (monthly).</li> </ul> </li> <li>• Approximately 35 consultations per month across outreach clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• A review of outreach clinics with Levin being held monthly and the potential for Dannevirke to have a SMO clinic.</li> <li>• The potential to review the Feilding clinic given patient volumes and transfer patients to MCH CNS clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased pressure on Palmerston North CNS-led clinic booking list/times.</li> <li>• Any individual patients having difficulty with access will be followed up by a CNS.</li> <li>• SMO clinics at Horowhenua will continue and the service will investigate the potential of a SMO clinic at Dannevirke now MCH has a second diabetologist.</li> <li>• The NP will continue to provide specialist clinics as is currently provided.</li> </ul>	<ul style="list-style-type: none"> <li>• Numbers on booking list.</li> <li>• Time from referral to first appointment.</li> <li>• Attendances at ED.</li> <li>• Admissions via ED of patients on booking list.</li> <li>• Re-referral to diabetes specialist service of patients discharged.</li> <li>• Mean HbA1c value</li> </ul>
		<ul style="list-style-type: none"> <li>• Increased attendances at/admissions via ED.</li> <li>• Decline in glucose control (cf MoH HbA1c target –</li> </ul>	

<ul style="list-style-type: none"> <li>2.6 FTE CNS undertaking remaining nurse-led clinics.</li> <li>Approximately 696 patients currently on active follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>2.4 FTE undertaking nurse-led clinics (saving 0.2 FTE).</li> <li>Patients with type 2 diabetes have maximum of three appointments then discharged back to General Practitioner (GP) care.</li> </ul>	<p>MidCentral currently ranks 16th out of 21).<sup>1</sup></p> <ul style="list-style-type: none"> <li>Increased waiting time from referral to first appointment.<sup>2</sup></li> <li>Increased admissions via ED due to delayed outpatient assessment and intervention.</li> <li>Increase of regional mean HbA1c measure of glucose control.</li> <li>Access to SMO clinics will increase at MCH given the appointment of a second Diabetologist.</li> <li>The NP clinics at MCH will continue.</li> <li>The booking times for CNS-led clinics will be managed by clinical priority as is the same for all booking lists across the organisation.</li> </ul>	<ul style="list-style-type: none"> <li>Numbers on booking list.</li> <li>Time from referral to first appointment.</li> <li>Attendances at ED.</li> <li>Admissions via ED of patients on booking list.</li> <li>Re-referral to diabetes specialist service of patients discharged.</li> <li>Mean HbA1c value</li> </ul>
<ul style="list-style-type: none"> <li>Regular telephone follow-up of/advice to patients by CNSs.</li> <li>Currently 52 hours per month (from CHIPS data).</li> <li>This approximates to 200 telephone consultations per</li> </ul>	<ul style="list-style-type: none"> <li>Telephone follow-up services will continue</li> <li>Any patients of any elective outpatient service within MCH who phone and are unwell are attended to as resources allow, otherwise patients are advised</li> </ul>	<ul style="list-style-type: none"> <li>The diabetes service will work on reviewing the number of telephone contacts currently undertaken with a view to some reprioritisation. Once this work has been</li> </ul>	<ul style="list-style-type: none"> <li>Mean HbA1c value</li> </ul>

<sup>1</sup> Landmark studies such as The Diabetes Control and Complications Trial (DCCT, 1993) and The United Kingdom Prospective Diabetes Study (UKPDS, 1998) – demonstrated that every 1 point reduction in HbA1c conferred a risk reduction of up to 33% for microvascular (e.g. blindness, kidney failure, nerve damage) and macrovascular complications (e.g. stroke, hypertension, heart disease, claudication, amputations) therefore the aim is to achieve an HbA1c at or below 7%. In the months 1 September through to end to November 2009 114 people were seen by MCH specialist diabetes nursing service. HbA1c levels were reduced in these patients by a mean of 0.79%. This reduction is over and above what General Practice had been able to achieve with these complex patients, thereby reducing significant morbidity for patients, reducing significant cost to MCH services and contributing to improving the district's health target of HbA1c of less than 8%.

<sup>2</sup> Currently 25% of referrals wait for less than one month, 33% wait for between 1-3 months, and 15% wait between 4-6 months.

month.	<ul style="list-style-type: none"> <li>• Triage nurse for acute referrals &amp; calls each day.</li> <li>• Approximately three calls taken each day.</li> </ul>	<p>to:</p> <ul style="list-style-type: none"> <li>o See GP.</li> <li>o Attend ED.</li> <li>o Dial 111.</li> </ul> <ul style="list-style-type: none"> <li>• No change proposed.</li> <li>• Priority to be given to acutely unwell patients.</li> <li>• Calls relating to surgical or diagnostic<sup>3</sup> elective procedures will continue unchanged.</li> </ul>	<p>completed any potential time saving will be reallocated into inpatient services.</p> <ul style="list-style-type: none"> <li>• The diabetes service will work with elective services to improve communications with diabetic patients. This will allow the service to plan care in a more timely way for patients who are to undergo an elective diagnostic/procedure.</li> </ul>	<ul style="list-style-type: none"> <li>• Elective surgical or diagnostic procedure elective waiting times.</li> </ul>
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<b>ADMINISTRATIVE</b>				
<b>Current Service</b>	<b>Proposed Service Change</b>	<b>Projected Impact/Mitigations</b>	<b>Audit Measure</b>	
<ul style="list-style-type: none"> <li>• 1.5 FTE for administrative and support services, including:               <ul style="list-style-type: none"> <li>o Clinic reception, booking appointments and arranging notes.</li> <li>o Same day typing of clinic letters.</li> <li>o Fielding calls from patients/GPs to the department.</li> <li>o Processing of referrals.</li> <li>o Management of</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Reduction to 1.0 FTE administrative.</li> </ul>	<ul style="list-style-type: none"> <li>• The typing of clinic letters can be extended up to three days so this is an area that can be extended. Urgent typing will still be completed same day.</li> <li>• Reception would be unattended at lunch time but is the same as other MCH departments that have one office administrator.</li> <li>• Processing of referrals (delays</li> </ul>	<ul style="list-style-type: none"> <li>• Patient satisfaction.</li> <li>• Patient complaints.</li> <li>• Time from dictation to typing of clinic and referral letters.</li> <li>• Time from receipt of referral to entering of appointment on system.</li> </ul>	

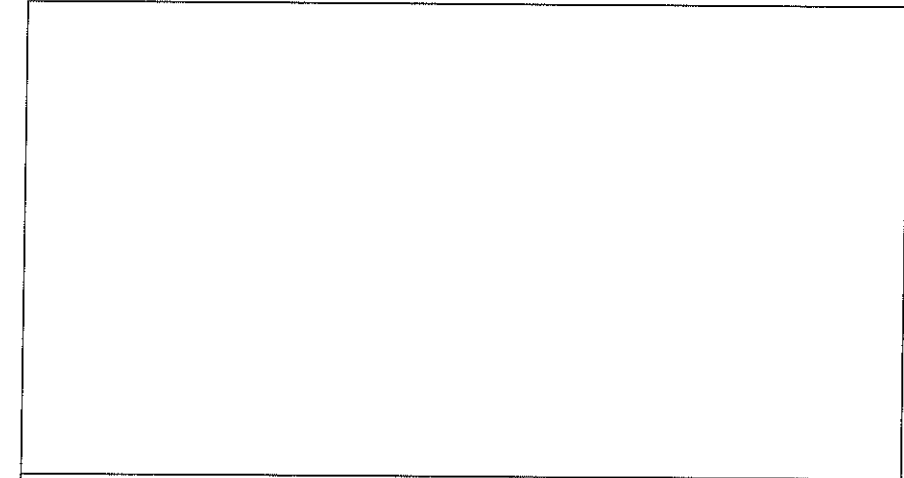
<sup>3</sup> Many surgical or diagnostic procedures require fasting and therefore people with diabetes on insulin or tablets are referred to the diabetes specialist nursing service for advice on adjusting their medication to ensure their risk of hypoglycaemia or hyperglycaemia is minimised during the procedure. Examples of procedures are colonoscopy, gastroscopy, intravenous urogram, computer tomography (CT) scan, magnetic resonance imaging (MRI), barium meals, cataract surgery, vitrectomy, dental extractions etc.

ordering/patient equipment supplies, clinical forms and petty cash.

- o Management of current client list and CHIPS data entry.
- o Data entry and support of departmental audit.

in appropriate triaging of patients) is a priority function and will not be impacted.

- Potential delays in CHIPS data entry. This can be supported across the organisation.
- The potential of any increase to Did Not Attend (DNA) rates by not telephoning the patients as is currently done by diabetes clerical staff can be mitigated by this function being provided by Central Patient Enquiries who perform this role for approximately 20 other clinics across the organisation.
- All administrative activity will be monitored and changes made if necessary. This will be managed by the Administration Coordinator responsible for the administrative staff within the Diabetes Service.



## 6. CONCLUSION

It is recognised the need to address the financial constraints placed upon the service by the DHB and plan a level of service appropriate to the funding available.

This paper outlines a way forward that seeks to minimise potential adverse effects while maintaining core service delivery to high risk patient groups.

Acute service provision at MCH remains available at all times.

A post event audit report of the Diabetes Service reconfiguration will be provided via the Hospital Advisory Committee by November 2011.

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**Medical Services**